LifeStream Behavioral Center, Inc

Describing the process of assessing, planning, providing and monitoring comprehensive integrated services through a case illustration

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LifeStream Behavioral Center, Inc.

- Cohort III
- Type of Program: Unified Primary Care and Behavioral Health/Reverse Co-Location Model (W.I.N. Clinic)
- Primary Care Model:
  - Evidence based models utilized include IMPACT and Motivational Enhancement Techniques (MET)
  - Embedded Nurse Care Managers
  - Wellness Services
  - Integrated services (psychiatric and primary care) are offered during the same visit
  - Specialty care is provided through agreements with community partners

The W.I.N. Clinic Staff-Who We Are

- **Medical Provider/Medical Consultant**

  Performs medical examinations, provides medical care, prescribes medications, and completes histories/physicals and psychiatric evaluations. Consults with other providers.

- **Lead Nurse Care Manager**

  Assists the medical provider, monitors care managers, prepares education packets for clients, recruits new clients and is responsible for marketing. Serves as the core for the clinic.

- **Nurse Care Managers**

  Responsible for home visits, charting, monitoring progress, treatment plans, education and teaching of consumers, and wellness activities.

- **Follow-up Specialist/Transporter**

  Responsible for contacting consumers for NOMS follow up; assisting clients with affordable prescriptions and referrals for patient assistance.

- **Administrative Support**

  Responsible for completing the NOMS, scheduling appointments, contacting referrals, and data entry.

Our Client Background

- **Demographics: "Matthew"** is a 56 y/o Caucasian male, high school graduate who completed trucking school, drives semi-trucks as a profession, raised in an Irish/Catholic family, moderate family support with history of substance abuse, family violence, legal system involvement (six felonies related to substance possession and aggression), divorced twice and has two estranged children.

- **Mental Health Needs**
  -Diagnosed as Bipolar and Agoraphobia
  -History of suicidal ideation
  -History of psychiatric hospital admissions
  -History of mood swings and violent temper

Our Client Background

- **Substance Use Issues**
  -Alcohol Dependence
  -Started drinking at 10 y/o
  -Averaging one gallon of vodka per day since the age of 15
  -At 42 y/o was incarcerated as a result of 3 DUI's
  -Cigarette smoker since the age of 15, averaging two packs/day
  -History of detoxification

- **Health problems**
  Hypertension, diabetes, high cholesterol, severe dehydration and insomnia. Blood work revealed elevated liver and kidney enzymes, decreased electrolytes, ETOH dementia and ataxia related to ETOH use.

Initial engagement in the PBHCI service model

- Nurse Care Managers present on the clinic services to LifeStream programs and outside referral sources on a regular basis.
- Referral process is simple. Potential patients are contacted within one business day to schedule initial appointment.
- Matthew was referred to the clinic after a presentation was done on the detoxification unit. He expressed interest in receiving services.
- Staff referred Matthew to the clinic as he was not medication compliant, experienced high cholesterol and blood pressure. Matthew had no active primary care.
- Referral information is considered an important data point.

Initial engagement in the PBHCI service model

- The Initial Visit Assessment is a critical data point and includes:

-PBHCI Clinical Registry (Lead Nurse Care Manager)
-Substance Abuse Audit (Lead Nurse Care Manager)
-Locus IV recovery Environment Subscale (Lead Nurse Care Manager)
-PHQ-9 (Lead Nurse Care Manager)
-SF-36 Subscales (Lead Nurse Care Manager)
-NOMS (Lead Nurse Care Manager)
-Vital signs (Lead Nurse Care Manager)
-Height and waist measurements (Lead Nurse Care Manager)
-Weight and BMI (Lead Nurse Care Manager)
-Behavioral Health Issues and Treatment (Lead Nurse Care Manager/Medical Provider)
-History & Physical (Medical Provider)
-Psychiatric Evaluation
-Medication Management (Medical Provider)
-Trauma (Lead Care Manager/Medical Provider)
-Smoking History and Cessation Attempts (Lead Nurse Care Manager/Medical Provider)

Initial engagement in the PBHCI service model

During the initial visit, Matthew also received:

- Education on support groups (Alcoholics Anonymous, Narcotics Anonymous, NAMI)
- Education on smoking cessation
- Education on coping skills
- Education on medication management
- Education/materials on his diagnosis
- Lab work appointment was provided
- Home visit with Nurse Care Manager was scheduled
- Warm Handoff!!

Assessment Process: Client H indicators plus additional health conditions

- During Matthew's initial visit, the information was collected by the Medical Provider and the Lead Nurse Care Manager.
- As Matthew had previous history of treatment and detoxification, psychiatric evaluations and substance abuse treatment documentation was included in the agency electronic health record. **This information is used during the intake to minimize the time it takes to complete the assessment.**
- Lead Nurse Care Manager gathers, organizes and presents all relevant information/data to the treatment team.
- Treatment team reviewed all of the available information and made treatment recommendations (behavioral health and primary care).
- For Matthew's review, the treatment team recommended utilizing a psychiatrist who specializes in addictions treatment to be part of the team and assist in completing the comprehensive integrated care assessment.
- Based on all the information gathered, a nurse care manager works with Matthew to develop a realistic treatment plan—utilizing motivational enhancement techniques.

Assessment Process: Client H indicators plus additional health conditions

H Indicators Initial Visit (9/27/2011) :

Blood Pressure: 180/98
BMI: 25 (Ht- 6'0" Wt- 188)

Blood Chemistry:
Glucose- 130 (high)
A1C- 6.4 (borderline high)
Cholesterol- 300 (high)
Triglycerides- 200 (high)
HDL- 33(low)
LDL- 149 (high)

Planning: Individualized Integrated Care Plan

A. Primary care services:

- After initial assessment, Matthew was scheduled for lab work. Once the results were in, Matthew had a follow up appointment with the Medical Provider to review and discuss the results.
- During the first month Matthew was seen every 2 weeks, and then was seen monthly for two months by the Medical Provider.
- During month 4 Matthew was seen every 3 months by the Medical Provider.
- Matthew receives weekly home visits from the Nurse Care Manager.
- Height, weight, BMI, blood pressure and glucose collected at each appointment.
- **Focus of service**
  Smoking cessation, substance abuse monitoring, medication management, nutrition/hydration monitoring, insomnia, hypertension and diabetes monitoring, blood work every three months to monitor diabetes, liver function, and electrolyte balance.

Planning: Individualized Care Plan

B. **Behavioral health service**

- Matthew is seen every three months by a psychiatrist at Lifestream Behavioral Center Mental Health/Substance Abuse Outpatient.
- Consults with WIN Clinic provider
- **Focus of service**
  Substance abuse, relapse prevention, medication compliance, medication side effect monitoring

Planning: Individualized Care Plan

C. **Wellness Activities/services**

- Nurse Care Manager meets with Matthew once a week at his house or at a public location.
- Reviews progress of H indicators with Matthew during each visit.
- Wellness seminars/education.

- **Types and focus of wellness related services**
  Smoking cessation, medication management, medication side effect monitoring nutrition/hydration monitoring, relapse prevention, hypertension and diabetes monitoring, coping skills, exercise education.

Progress Monitoring (H indicators and other health conditions)

- Lab work is done at the clinic every three months to monitor liver, diabetes, and cholesterol.
- Vital signs, weight and waist measurements done weekly by Nurse Care Manager. Health status indicators monitored at regular PC appointments.
- Follow up appointment every 3 months to monitor medications, vital signs, weight management, and to review blood work.
- All lab work is faxed to the psychiatrist's office along with most recent vital signs and weight.
- All staff involved with the care are able to access and share information.
- Treatment team regularly reviews all information.

Matthew's Progress

- Since Matthew was seen at WIN he has not been admitted to detox. He has maintained sobriety since 9/20/2011.
- Matthew has not been hospitalized or reports any suicidal ideation.
- Upon admission to the clinic, Matthew was on two blood pressure medications, he is currently on one.
- Matthew is no longer smoking.
- ETOH dementia is currently not evident.
- Matthew attends AA on a regular basis.
- He completed anger management class and continues to work with the Nurse Care Manager on various related issues.
- Matthew is working full time.
- Matthew is medication compliant.
- Matthew has reunited with his children.

Assessment Process: Client H indicators plus additional health conditions (recent)

H Indicators Initial Visit (9/27/2011)

Blood Pressure: 180/98
BMI: 25 (Ht- 6'0" Wt-188)

Blood Chemistry:
Glucose- 130 (high)
A1C- 6.4 (borderline high)
Cholesterol- 300 (high)
Triglycerides- 200 (high)
HDL- 33(low)
LDL- 149 (high)

H Indicators Follow Up visit (1/14/2013)

Blood Pressure: 138/80
BMI: 24 (Ht-6'0" Wt-183)

Blood Chemistry:
Glucose-89
A1C- 5.8
Cholesterol- 202
Triglycerides- 141
HDL- 39 (borderline low)
LDL- 135 (high)

How has the individualized assessment, planning, service delivery and monitoring process influenced organizational policy decisions?

- Primary Care and health issues are part of the treatment process
- Realization that integrated care is the best care
- Integrated care is part of strategic thinking and planning
- EHR focus